VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 31, 2012

Ms. Wendy Beatty, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201

Provider # 475027

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 14, 2011.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced on-site annual recertification survey from 12/12/11 to 12/14/11. The following regulatory deficiencies were identified:	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide for 2 residents of the sample group [Resident #39 & Resident #51] an environment in the main dining room at the lunch and supper meals that maintains or enhances each resident's dignity and respect. The findings include: 1. Per observation on 12/12/11 at 11:35 A.M., 17 residents, including Resident #39 and Resident #51, were seated for the noon meal in the facility's 3rd Floor Dining Room. At 12:25 P.M., after the majority of residents had finished their meals and left the dining room, 50 minutes after being seated, Resident #39 was asked what s/he wanted to eat for lunch. Resident #39 requested and received a salad, and simultaneously was given a dessert. Resident #51, seated at the same table as Resident #39 and waiting for his/her meal, was also given a dessert at this time. Per interview with Resident #39 on 12/13/11	F 241	**Plan of Correction** **F241** **1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Residents #39 and #51 preferred dining times were reassessed and changed to accommodate their preferred times. The residents suffered no negative effects from this alleged deficient practice. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Residents who eat in the dining room are at risk to receive their meals late. **3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;** Dining room staff will be in re-educated on timeliness of serving residents who are seated in the dining room, especially those residents seated at the same table. F241 POC approved T. Cummings RN. Cont... #38237 1/14/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

NHA | 1.10.12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 at 9:23 A.M., s/he confirmed that s/he has to wait a long time for his/her meals each day and that this was not acceptable to Resident #39. Per interview with Resident #51 at 12:25 P.M. on 12/12/11 when asked if s/he was hungry replied "yes" and if s/he had been waiting a long time for his/her lunch replied "yes". At 12:35 P.M. (60 minutes after arriving in the Dining Room) Resident #51 was given a sandwich and was assisted with eating by a Licensed Nursing Assistant. 2. Per observation on 12/12/11, Resident #39 was seated in the main dining room at 4:35 P.M. At 4:50 P.M. the only other resident at the table was served his/her meal. Resident #39 was not served his/her meal until 5:12 P.M. Per interview with Resident #39 on 12/13/11 at 9:23 A.M., s/he confirmed that s/he has to wait a long time for his/her meals each day and that this was not acceptable to Resident #39.	F 241	**4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Weekly audits x 4, then monthly audits x2 will be done to monitor compliance to meal service. Results will be reported to the QAA committee on monthly basis. **5. Dates Corrective Action will be completed:** Responsible: Nurse Manager, In Service Director or designee. January 13, 2012	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	**F280** **1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #115 was interviewed and incontinence was addressed .Initiation of a bowel and bladder assessment was declined by this resident as she did not feel that she had a problem. Care plan was updated. There were no negative outcomes. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Residents who are continent are at risk.	

F280 P.O.C approved T. Lunn RN 28237 1/11/12

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F 280	Continued From page 2 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to develop a plan of care for one resident in the applicable Stage 2 sample who had a change in bladder function. (Resident #115) Findings include: Per record review of the Nursing Notes, Comprehensive Review dated 9/1/11, LNA Charting concerning urinary continence, and verified during staff interview with the Unit A Nursing Supervisor on 12/13/11 at 4:55 PM, Resident #115 was admitted continent of urine on 8/23/11, became incontinent of urine with three episodes of incontinence on 11/19/11, 11/20/11, and 12/1/11 and a plan of care was not developed for the change in bladder function. In addition, the Nursing Supervisor stated that a facility Voiding Pattern Evaluation Tool was not completed for Resident #115.	F 280	**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** Residents will have a bowel and bladder assessment initiated on admission to determine continence. The care plan will updated to reflect this assessment. A change in continence will be evaluated on the MDS cycle and discussed at care plan as appropriate. If a change is noted on the review of the MDS cycle, resident will be evaluated and care plan updated with appropriate interventions and resident/family involvement. Changes that occur between MDS cycle will be addressed at the time the change occurs and appropriate interventions done and noted on care plan. Staff will be educated regarding reporting changes in continence between MDS cycle as well as the importance of resident participation in decision making with regards to continence. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Random audits of LNA bladder continence charting on new admissions to monitor for changes weekly x4 then monthly x2. Random audits of MDS to monitor for changes in bladder continence weekly x 4 then monthly x2 Any new incontinence noted from the 24 hour report will be acted upon appropriately. **5. Dates Corrective Action will be completed:** January 13,, 2012 Responsible:ADNS, Nurse Managers, In Service Director or designee.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

F 280 POC approved T. Cummings RN 28237 1/19/12

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F 329	Continued From page 3 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assure that residents were free from unnecessary drugs when there was a failure to have adequate indications for the use of drugs and/or not discontinuing medications that were not used or not needed based on lab monitoring in 3 of 10 residents in the applicable sample. (Residents # 91,104, 118) Findings include: 1. Per record review on 12/14/11, there were three medications for Resident #104 that did not have indications for their use, including one anti-histamine and two anti-gout drugs. Per review of the physician progress notes, there was no diagnosis listed to indicate why these medications were being used. On 12/14/11 at	F 329	F329 **1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #104 remains on allopurinol and colchicine. MD has written progress note to support the use of these 2 agents. Resident #104 has a diagnosis for the use of an antihistamine. Resident# 91 has had appropriate discontinuation of PRN meds that have not been used in the past 60 days. Resident #118 continues on Zocor. His MD acknowledged that he reviewed his labs and wishes to make no changes at the present time. No negative outcomes were noted from this alleged deficient practice. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Residents with unused PRN meds are at risk. Residents on medications without supporting documentation are at risk. Residents records to be reviewed for unused PRNs and documentation of supporting diagnosis. F 329 POC approved Cont... 1. Summary RN #2223... 1/19/12	

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F 329	Continued From page 4 1:40 P.M., the unit manager confirmed that there was no indication for the use of these medications in the patient's record and no evidence that staff had contacted the physician to obtain a diagnosis. 2. Per medical record review on 12/14/2011 at 9:02 AM, Resident #91 had many unused PRN (as needed) medications that continue to be listed on the MAR, (Medication Administration Record), including phenergan. During staff interview at 10:59 AM on 12/14/2011, staff indicates that the facility protocol is to discontinue a medication if it has not been used in 60 days. Per review of the old MAR forms, the PRN medications Tylenol, zyrtec, benadryl, albuterol inhaler and the bowel program medications, as well as phenergan have not been used during Sept, Oct, Nov or Dec 2011. Pharmacy recommendations dated 9/23/2011 recommend that nursing review PRN medications with the physician to discontinue the unused medications. There is no evidence in the chart to indicate that this recommendation has been addressed. Staff confirm during interview at 11:00 AM on 12/14/2011 that pharmacy recommendations to discontinue unused medications, especially phenergan for Resident #91 have not been followed and that unused medications continue to be on the active, signed medication orders. See F 428. 3. Per medical record review on 12/13/2011 at 4:38 PM, Resident #118 had labs ordered to monitor for cholesterol levels to justify the use of	F 329	**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** MARS will be reviewed monthly for unused PRN medication. Weekly random audits x4 to monitor for compliance of discontinuation of unused PRN Meds then monthly x2. Charts will be reviewed monthly for medications that do not have supporting diagnosis. Random weekly audits x 4, then monthly x2 will be conducted to monitor for compliance. Results will be reported through the QAA committee. Faxes and pharmacy recommendations will be reviewed for MD and nursing response. Random weekly audits x 4 and then monthly x 2 will be conducted to monitor compliance. Results will be reported to the QAA committee monthly. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Staff will receive education of discontinuation of unused PRN medications as well as the necessity of supporting diagnosis for medications, Staff will also receive education on monitoring MD responses to fax and following pharmacy recommendations. **5. Dates Corrective Action will be completed:** Responsible: Nurse Managers In-service Director or designee. 1.13.2012	F329 POC approved 1. Lamp RN #28437 1/19/12

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F 329	Continued From page 5 Zocor, a cholesterol lowering medication, that was being administered. Labs were ordered for cholesterol levels and the levels were reported on 11/15/2011 to be low. The lab values were faxed to the MD on 11/15/2011. There is no evidence in the medical record to indicate that the MD responded to the fax and the resident remains on Zocor to date. It is confirmed by the staff nurse during interview on 12/13/2011 at 5:15 PM that there is no evidence to indicate that the physician responded to the faxed report and staff further confirm that Resident #118 has received Zocor for 28 days after the lab values were faxed to the MD.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the pharmacist failed to report irregularities to the attending physician and/or the facility staff failed to act on pharmacy recommendations for 2 of 10 residents in the applicable sample. (Residents	F 428	**F428** **1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #104 continues on colchicine and allopurinol. There is a diagnosis and progress note to support the use of these 2 drugs. There were no negative outcomes associated with this alleged deficient practice. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Residents with unused PRN meds are at risk. Residents on medications without supporting documentation are at risk. Residents records to be reviewed for unused PRNs and documentation of supporting diagnosis. Cont. . .	F 428 POC approved T. Cummings #88237 1/19/12

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F 428	Continued From page 6 #91 & #104) Findings include: 1. Per record review on 12/14/11, there were two medications for Resident #104 that did not have a corresponding diagnosis for use. Both medications are considered anti-gout medications. The first of two anti-gout medications had been ordered by the physician on August 27, 2011. Per review of the physician progress notes, there was no diagnosis listed to indicate why these medications were being used. On 12/14/11 at 1:40 P.M., the unit manager confirmed that there was no indication for the use of these medications in the patient's record and no evidence that staff had contacted the physician to obtain a diagnosis. Per review of pharmacy reviews conducted, the lack of indications or a diagnosis for use of the medications was not reported by the pharmacist. 2. Per medical record review on 12/14/2011 at 9:02 AM, Resident #91 had many unused PRN (as needed) medications that continue to be listed on the MAR (Medication Administration Record), including phenergan. During staff interview at 10:59 AM on 12/14/2011, staff indicates that the facility protocol is to discontinue a medication if it has not been used in 60 days. Per review of the old MAR forms, the PRN medications Tylenol, zyrtec, benadryl, albuterol inhaler and the bowel program medications, as well as phenergan have not been used during Sept, Oct, Nov or Dec 2011. Pharmacy recommendations dated 9/23/2011 recommend that nursing review PRN medications	F 428	**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** MARS will be reviewed monthly for unused PRN medication. Weekly random audits x4 to monitor for compliance of discontinuation of unused PRN Meds then monthly x2. Charts will be reviewed monthly for medications that do not have supporting diagnosis. Random weekly audits x 4, then monthly x2 will be conducted to monitor for compliance. Results will be reported through the QAA committee. Faxes and pharmacy recommendations will be reviewed monthly for MD and nursing response. Random weekly audits x 4 and then monthly x 2 will be conducted to monitor compliance. Results will be reported to the QAA committee monthly. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Staff will receive education of discontinuation of unused PRN medications as well as the necessity of supporting diagnosis for medications, Staff will also receive education on monitoring MD responses to fax and following pharmacy recommendations. **5. Dates Corrective Action will be completed:** Responsible: Nurse Managers, Consultant Pharmacist, in-service Director or designee. 1.13.2012	

F 428 POC approved T. Cummings RN #28237 1/19/12

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F 428	Continued From page 7 with the physician to discontinue the unused medications. There is no evidence in the chart to indicate that this recommendation has been addressed. Staff confirm during interview at 11:00 AM on 12/14/2011 that pharmacy recommendations to discontinue unused medications, especially phenergan for Resident #91 have not been followed and that unused medications continue to be on the active, signed medication orders.	F 428		
F 468 SS=B	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to equip facility corridors with firmly secured handrails on each side. The findings include: Per observation on 12/14/11 at 8:25 AM, during the environmental tour, it was observed by the surveyor that 3 handrails along the left side of the North unit on the 3rd floor were loose. When pulled, the handrails moved away from the wall approximately 1/4 inch on each end creating a small gap between the railing and the wall. The gap created is wide enough for a resident's hand/finger to become pinched. Per interview with the Director of Environmental Services on 12/14/11 at 8:25 AM he/she confirmed that a gap was created from the loose handrails on the 3rd floor, and this was a cause of concern for potential injury to residents' hands/fingers.	F 468	F468 Hand rails have been firmly secured to the wall. Director of Maintenance has added checking of handrails to the preventative maintenance schedule and will be checked monthly. F 468 POC approved 1. Cummings RN # 28237 1/19/12	

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